FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042879

Facility Name: Provena McAuley Manor

Address: 400 West Sullivan Road (Number) Aurora (City) 60506 (Zip Code)

County: Kane

Telephone Number: (630) 859-3700 **Fax #** (630) 264-1862

IDPA ID Number: 371127787012

Date of Initial License for Current Owners: 12/01/97

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 C3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Lynda Olinski **Telephone Number:** (708) 478-7916

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Michael R. Gordon

(Title) VP of Finance, CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	87	Skilled (SNF)	87	31,755	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	87	TOTALS	87	31,755	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,189	14,195	8,408	23,792	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,189	14,195	8,408	23,792	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.92%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/1/1997

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 42 and days of care provided 8,408

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	181,132	40,940	9,489	231,561		231,561		231,561			1
2	Food Purchase		130,536		130,536		130,536	(12,125)	118,411			2
3	Housekeeping	132,546	16,859	936	150,341		150,341		150,341			3
4	Laundry	22,929	7,436	39,235	69,600		69,600	(16,252)	53,348			4
5	Heat and Other Utilities			129,509	129,509		129,509	863	130,372			5
6	Maintenance	75,778	21,103	50,813	147,694		147,694	35,551	183,245			6
7	Other (specify):* **Pastoral Care/Dev.**	34,442	2,411	46,685	83,538		83,538	(28,160)	55,378			7
8	**TOTAL General Services**	446,827	219,285	276,667	942,779		942,779	(20,123)	922,656			8
	B. Health Care and Programs											
9	Medical Director			18,429	18,429		18,429		18,429			9
10	Nursing and Medical Records	1,589,245	167,340	473,084	2,229,669		2,229,669		2,229,669			10
10a	Therapy			475,117	475,117		475,117		475,117			10a
11	Activities	66,375	1,755	13,891	82,021		82,021	946	82,967			11
12	Social Services	32,911	87	221	33,219		33,219		33,219			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,688,531	169,182	980,742	2,838,455		2,838,455	946	2,839,401			16
	C. General Administration											
17	Administrative	308,962	11,425	444,000	764,387		764,387	(194,842)	569,545			17
18	Directors Fees											18
19	Professional Services			17,321	17,321		17,321	193,030	210,351			19
20	Dues, Fees, Subscriptions & Promotions			36,993	36,993		36,993	(16,215)	20,778			20
21	Clerical & General Office Expenses			41,374	41,374		41,374	(9,251)	32,123			21
22	Employee Benefits & Payroll Taxes			503,652	503,652		503,652	86,435	590,087			22
23	Inservice Training & Education			6,744	6,744		6,744	2,897	9,641			23
24	Travel and Seminar			3,638	3,638		3,638	3,236	6,874			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			93,800	93,800		93,800	3,476	97,276			26
27	Other (specify):* **Bad Debt**			140,439	140,439		140,439	(140,439)				27
28	**TOTAL General Administration**	308,962	11,425	1,287,961	1,608,348		1,608,348	(71,673)	1,536,675			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,444,320	399,892	2,545,370	5,389,582		5,389,582	(90,850)	5,298,732			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Provena McAuley Manor #0042879 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			294,644	294,644		294,644	74,705	369,349			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							96,838	96,838			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							8,680	8,680			34
35	Rent-Equipment & Vehicles			5,604	5,604		5,604	460	6,064			35
36	Other (specify):*											36
37	**TOTAL Ownership**			300,248	300,248		300,248	180,683	480,931			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			515,013	515,013		515,013		515,013			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,763	47,763		47,763		47,763			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			562,776	562,776		562,776		562,776			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,444,320	399,892	3,408,394	6,252,606		6,252,606	89,833	6,342,439			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,679)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(16,252)	4		8
9	Non-Straightline Depreciation	13,591	30		9
10	Interest and Other Investment Income	(3,694)	32		10
11	Discounts, Allowances, Rebates & Refunds	(16,110)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(140,439)	27		24
25	Fund Raising, Advertising and Promotional	(21,386)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (197,969)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	315,962		34
35	Other- Attach Schedule	(28,160)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 287,802		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 89,833		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Provena McAuley Manor

ID# 0042879

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development - Postage	$ (7)	7	1
2	Development - Travel	(156)	7	2
3	Development - Education/Conf	(60)	7	3
4	Development - Misc.	(27,862)	7	4
5	Development - Office Supplies	(75)	7	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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19				19
20				20
21				21
22				22
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31				31
32				32
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(28,160)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena McAuley Manor # 0042879 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(13,679)	1,554	0	0	0	0	0	0	0	0	0	(12,125)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(16,252)	0	0	0	0	0	0	0	0	0	0	(16,252)	4
5	Heat and Other Utilities	0	863	0	0	0	0	0	0	0	0	0	863	5
6	Maintenance	0	303	35,248	0	0	0	0	0	0	0	0	35,551	6
7	Other (specify):*	(28,160)	0	0	0	0	0	0	0	0	0	0	(28,160)	7
8	**TOTAL General Services**	(58,091)	2,720	35,248	0	0	0	0	0	0	0	0	(20,123)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	946	0	0	0	0	0	0	0	0	0	946	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	946	0	0	0	0	0	0	0	0	0	946	16
	C. General Administration													
17	Administrative	0	(174,264)	(20,578)	0	0	0	0	0	0	0	0	(194,842)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	17,355	175,675	0	0	0	0	0	0	0	0	193,030	19
20	Fees, Subscriptions & Promotions	(21,386)	5,171	0	0	0	0	0	0	0	0	0	(16,215)	20
21	Clerical & General Office Expenses	(16,110)	6,859	0	0	0	0	0	0	0	0	0	(9,251)	21
22	Employee Benefits & Payroll Taxes	0	27,804	58,631	0	0	0	0	0	0	0	0	86,435	22
23	Inservice Training & Education	0	2,897	0	0	0	0	0	0	0	0	0	2,897	23
24	Travel and Seminar	0	3,236	0	0	0	0	0	0	0	0	0	3,236	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	3,476	0	0	0	0	0	0	0	0	0	3,476	26
27	Other (specify):*	(140,439)	0	0	0	0	0	0	0	0	0	0	(140,439)	27
28	**TOTAL General Administration**	(177,935)	(107,466)	213,728	0	0	0	0	0	0	0	0	(71,673)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(236,026)	(103,800)	248,976	0	0	0	0	0	0	0	0	(90,850)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Provena McAuley Manor** **#** **0042879** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	13,591	0	61,114	0	0	0	0	0	0	0	0	74,705	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,694)	0	100,532	0	0	0	0	0	0	0	0	96,838	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	8,680	0	0	0	0	0	0	0	0	8,680	34
35	Rent-Equipment & Vehicles	0	0	460	0	0	0	0	0	0	0	0	460	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	9,897	0	170,786	0	0	0	0	0	0	0	0	180,683	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(226,129)	(103,800)	419,762	0	0	0	0	0	0	0	0	89,833	45

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Provena Senior Services	100.00%	$ 1,554	$ 1,554	1
2	V	5	Utilities		Provena Senior Services	100.00%	863	863	2
3	V	6	Maintenance - Other		Provena Senior Services	100.00%	303	303	3
4	V	11	Activities-Special Events		Provena Senior Services	100.00%	946	946	4
5	V	17	Admin - Misc. Other	283,200	Provena Senior Services	100.00%	8,108	(275,092)	5
6	V	17	Administrative Salaries		Provena Senior Services	100.00%	100,828	100,828	6
7	V	19	Professional Services		Provena Senior Services	100.00%	17,355	17,355	7
8	V	20	Dues,Subscriptions		Provena Senior Services	100.00%	5,171	5,171	8
9	V	21	Clerical Supplies		Provena Senior Services	100.00%	6,859	6,859	9
10	V	22	Employee Benefits		Provena Senior Services	100.00%	27,804	27,804	10
11	V	23	Education/Conference		Provena Senior Services	100.00%	2,897	2,897	11
12	V	24	Travel		Provena Senior Services	100.00%	3,236	3,236	12
13	V	26	Insurance		Provena Senior Services	100.00%	3,476	3,476	13
14	Total			$ 283,200			$ 179,400	$ * (103,800)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Provena Senior Services	100.00%	$ 1,649	$ 1,649	15
16	V	32	Interest		Provena Senior Services	100.00%	100,532	100,532	16
17	V	34	Rent - Facility		Provena Senior Services	100.00%	8,680	8,680	17
18	V	35	Rent - Equipment		Provena Senior Services	100.00%	460	460	18
19	V	17	Admin Salaries	94,800	Provena Health Services	100.00%	62,337	(32,463)	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	26,065	26,065	20
21	V	30	Depreciation		Provena Health Services	100.00%	59,465	59,465	21
22	V	19	Admin Consulting,Other		Provena Health Services	100.00%	175,675	175,675	22
23	V	17	Information Systems Salaries	66,000	Provena Health Services	100.00%	14,259	(51,741)	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	5,962	5,962	24
25	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	6,360	6,360	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	38,905	38,905	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	16,267	16,267	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	24,721	24,721	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	10,337	10,337	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	28,888	28,888	30
31	V	39	Ancillary Services - Other	515,013	Provena Senior Services Pharmacy	100.00%	515,013		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 675,813			$ 1,095,575	$ * 419,762	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services
Street Address: 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code: Mokena, IL60448
Phone Number: (708)478-7900
Fax Number: (708)478-5387

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income	5,261,654	20	$ 28,878	$	283,200	$ 1,554	1
2	5	Utilities	Management Fee Income	5,261,654	20	16,037		283,200	863	2
3	6	Maintenance - Other	Management Fee Income	5,261,654	20	5,629		283,200	303	3
4	11	Activities-Special Events	Management Fee Income	5,261,654	20	17,583		283,200	946	4
5	17	Admin - Misc. Other	Management Fee Income	5,261,654	20	150,633		283,200	8,108	5
6	17	Administrative Salaries	Management Fee Income	5,261,654	20	1,873,311	1,873,311	283,200	100,828	6
7	19	Professional Services	Management Fee Income	5,261,654	20	322,442		283,200	17,355	7
8	20	Dues,Subscriptions	Management Fee Income	5,261,654	20	96,069		283,200	5,171	8
9	21	Clerical Supplies	Management Fee Income	5,261,654	20	127,431		283,200	6,859	9
10	22	Employee Benefits	Management Fee Income	5,261,654	20	516,585		283,200	27,804	10
11	23	Education/Conference	Management Fee Income	5,261,654	20	53,828		283,200	2,897	11
12	24	Travel	Management Fee Income	5,261,654	20	60,116		283,200	3,236	12
13	26	Insurance	Management Fee Income	5,261,654	20	64,582		283,200	3,476	13
14	30	Depreciation	Management Fee Income	5,261,654	20	30,629		283,200	1,649	14
15	32	Interest	Management Fee Income	5,261,654	20	1,867,812		283,200	100,532	15
16	34	Rent - Facility	Management Fee Income	5,261,654	20	161,270		283,200	8,680	16
17	35	Rent - Equipment	Management Fee Income	5,261,654	20	8,543		283,200	460	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,401,378	$ 1,873,311		$ 290,721	25

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Health Services
Street Address: 9223 West St. Francis Road
City / State / Zip Code: Frankfort, IL 60423
Phone Number: (815)469-4888
Fax Number: (815)469-4864

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin Salaries	Operating Expense	1,146,264	10	$ 753,738	$ 753,738	94,800	$ 62,337	1
2	22	Employee Benefits	Operating Expense	1,146,264	10	315,161		94,800	26,065	2
3	30	Depreciation	Operating Expense	1,146,264	10	719,013		94,800	59,465	3
4	19	Admin Consulting,Other	Operating Expense	1,146,264	10	2,124,158		94,800	175,675	4
5	17	Information Systems Salaries	Operating Expense	791,616	10	171,021	171,021	66,000	14,259	5
6	22	Information Systems Benefits	Operating Expense	791,616	10	71,509		66,000	5,962	6
7	6	Information Systems - Equip Mair	Operating Expense	791,616	10	76,287		66,000	6,360	7
8	17	Admin Salaries	Direct Cost	1,146,264	10	470,416	470,416	94,800	38,905	8
9	22	Employee Benefits	Direct Cost	1,146,264	10	196,696		94,800	16,267	9
10	17	Information Systems Salaries	Direct Cost	791,616	10	296,512	296,512	66,000	24,721	10
11	22	Information Systems Benefits	Direct Cost	791,616	10	123,981		66,000	10,337	11
12	6	Information Systems - Equip Mair	Direct Cost	791,616	10	346,486		66,000	28,888	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,664,978	$ 1,691,687		$ 469,241	25

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services Pharmacy
Street Address: 1475 Harvard Drive
City / State / Zip Code: Kankakee, IL 60901
Phone Number: (815)928-6141
Fax Number: (815)946-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			$	$		$ 515,013	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 515,013	25

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Provena Senior Services										96,838	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 96,838	14
15	TOTALS (line 9+line14)						$	$			$ 96,838	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Provena McAuley Manor **#** 0042879 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Provena McAuley Manor COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0042879

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	87		1986		$ 4,218,962	$ 168,758	25	$ 168,758	$	$ 3,290,791	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	36,401		15			36,401	9
10	Various			1988	47,074	592	16	592		42,733	10
11	Various			1989	20,698		15			20,698	11
12	Various			1990	25,276	833	13	833		25,276	12
13	Various			1991	44,027	2,775	15	2,775		40,384	13
14	Various			1992	120,907	7,415	14	7,415		100,638	14
15	Various			1993	133,363	7,855	13	7,855		111,618	15
16	Various			1994	32,534	836	11	836		29,691	16
17	Various			1995	22,015		8			22,015	17
18	Various			1996	70,791	4,318	8	4,318		43,942	18
19	Various			1997	20,454	181	6	181		19,296	19
20	Various			1999	35,104	2,198	6	2,198		29,374	20
21	Various			2000	43,053	2,778	10	2,778		18,343	21
22	Various			2001	95,377	13,250	6	13,250		60,021	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DESC: INSTALL RPZ	2002	$ 7,981	$ 798	10	$ 798	$	$ 2,793	37
38	DESC: SHEET VINYL FLOORING IN 3 ELEVATORS	2002	1,685	337	5	337		1,180	38
39	DESC: WALL REPAIRS / PAINTING	2002	4,275	855	5	855		2,993	39
40	DESC: ROOF AND DECK REPLACEMENT	2002	4,639	464	10	464		1,624	40
41	DESC: DRYWALL REPLACEMENT / PAINTING	2002	1,000	200	5	200		700	41
42	DESC: BORDER WALLCOVERING	2002	960	192	5	192		672	42
43	DESC: PAINTING AND ERPAIR OF COORIDORS/HAL	2002	6,213	1,243	5	1,243		3,728	43
44	DESC: PAINTING CUSTOMER LOUNGE, PATIENTS'	2002	1,200	240	5	240		720	44
45	DESC: REPLACE HOT WATER BOILER AND HEATERS	2002	14,331	1,433	10	1,433		4,299	45
46	DESC: NEW WALK PATHS	2002	19,377	2,422	8	2,422		7,266	46
47	DESC: REPLACEMENT FLOORING ALTZHEIMER UNIT	2002	11,967	2,393	5	2,393		7,180	47
48	DESC: REPLACEMENT FLOORING FOR FAMILY LOUN	2002	1,258	252	5	252		755	48
49	DESC: FREIGHT	2002	260	52	5	52		156	49
50	DESC: BORDER WALL COVERINGS	2002	85	17	5	17		51	50
51	DESC: ROOF REPAIRS	2002	3,800	253	15	253		760	51
52									52
53	DESC: CARPET RELACEMENT- LOUNGE AND ADMINI	2003	10,515	2,103	5	2,103		5,257	53
54	DESC: REPIPE CIRCULATING LINE AND INSTALL	2003	3,000	300	10	300		750	54
55	DESC: VACUUM PUMP	2003	1,847	369	5	369		924	55
56	DESC: FREON	2003	1,511	302	5	302		756	56
57	DESC: 50 GALLON ELECTRIC WATER HEATER	2003	4,758	476	10	476		1,190	57
58	DESC: PRIVATE CABLE TV SYSTEM	2003	22,812	2,281	10	2,281		5,703	58
59	DESC: PAINT ROOMS	2003	15,000	3,000	5	3,000		7,500	59
60	DESC: REFRIGERATION/COOLING CLEANING AND A	2003	3,355	671	5	671		1,678	60
61	DESC: PLEATED SHADES	2003	10,048	2,010	5	2,010		4,019	61
62	DESC: REPLACE 3 B&G HEATING PUMPS	2003	6,094	609	10	609		609	62
63	DESC: BORDER WALLCOVERING	2003	425	85	5	85		213	63
64	DESC: 2ND FLOOR NURSES STATION	2003	26,960	1,797	15	1,797		3,595	64
65	DESC: WALL SCONCES AND BORDER	2003	666	67	10	67		133	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,152,055	$ 237,013		$ 237,013	$	$ 3,958,422	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,152,055	$ 237,013		$ 237,013	$	$ 3,958,422	1
2	DESC: VOICE MAIL	2004	2,307	231	10	231		346	2
3	DESC: CCTV SYSTEM UPGRADE	2004	2,690	179	15	179		269	3
4	DESC: ALUMINUM DOORS	2004	4,500	225	20	225		338	4
5	DESC: COMPRESSOR REPAIR OF WALK IN FREEZER	2004	3,356	671	5	671		671	5
6	DESC: CALLXPRESS SOFTWARE	2004	3,590	718	5	718		1,077	6
7	DESC: ELEVATOR MOTOR	2004	2,900	145	20	145		218	7
8	DESC: ROOF REPAIR AND MAINTENANCE	2004	1,816	363	5	363		545	8
9	DESC: RESURFACE PAVING FOR PARKING LOT & R	2004	14,900	1,863	8	1,863		2,794	9
10	DESC: CONTROL RELACEMENT ON BOILER & CHILL	2004	47,000	4,700	10	4,700		7,050	10
11	DESC: ALUMINUM DOOR W/ SIDELITE FRAME	2004	1,900	190	10	190		285	11
12	DESC: REPLACE CONCRETE 8FT x 11FT IN ENTRY	2004	1,850	123	15	123		185	12
13	DESC: INSTALLED 30 YEAR SHINGLE ON THE CHA	2004	6,745	675	10	675		675	13
14	DESC: REPLACE PUMP W/ B&G PUMP	2004	3,728	373	10	373		373	14
15	DESC: DISHWASHER	2004	1,950	195	10	195		195	15
16	DESC: 100V DOOR HOLDERS & WIREMOLD LOW VOL	2004	1,117	223	5	223		223	16
17	DESC: EXTERIOR ELECTOHDRALIC DOOR AND INTE	2004	4,025	403	10	403		403	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,256,429	$ 248,290		$ 248,290	$	$ 3,974,067	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,256,429	$ 248,290		$ 248,290	$	$ 3,974,067	1
2	DESC: CONVENT SCREENS	2005	3,200	320	5	640	320	640	2
3	DESC: DRAIN PIPING AND REROUTE PIPING	2005	512	26	10	51	26	51	3
4	DESC: LENNOX HS29-018 CONDENSING UNIT & 2	2005	12,000	400	15	800	400	800	4
5	DESC: INSTALL CIRCUIT BREAKER PANEL & HVAC	2005	10,535	351	15	702	351	702	5
6	DESC: COADE ALERT - WANDERER SYSTEM	2005	3,435	172	10	344	172	344	6
7	DESC: INSTALL 1ST FLOOR NURSES STATION/PHY	2005	40,700	1,357	15	2,713	1,357	2,713	7
8	DESC: DRYWALL AND TAPING WORK	2005	1,630	82	10	163	82	163	8
9	DESC: FURNISH AND INSTALL SOFT STARTERS FO	2005	2,623	131	10	262	131	262	9
10	DESC: WANDERER SYSTEM	2005	3,583	179	10	358	179	358	10
11	DESC: KM SYSTEMS 2100 SERIES ELECTROHYDRAL	2005	4,031	202	10	403	202	403	11
12	DESC: REPLACE CONCRETE AT LOWER AND TOP PA	2005	16,390	546	15	1,093	546	1,093	12
13	DESC: IDPH REQ. REPAIRS	2005	23,370	1,169	10	2,337	1,169	2,337	13
14	DESC: REPAIR OF SEWER IN DISWASHING ROOM	2005	4,192	210	10	419	210	419	14
15	DESC: EXTERIOR METAL HANDRAILS AND ENAMEL	2005	1,585	79	10	159	79	159	15
16	DESC: FIRE PROTECTION SUPRESSION SPRINKLER	2005	16,150	323	25	646	323	646	16
17	DESC: GENERAL MAINT. AND BASE FLASHING REP	2005	9,850	493	10	985	493	985	17
18	DESC: RENOVATION OF BATHROOMS	2005	11,024	367	15	735	367	735	18
19	DESC: CARPETING FOR HALL/CHAPEL HALL/ ADMI	2005	9,804	980	5	1,961	980	1,961	19
20	DESC: REPLACE CURB AND SIDEWALKS	2005	15,840	528	15	1,056	528	1,056	20
21	DESC: 3 RAIL FENCING	2005	3,691	123	15	246	123	246	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,450,574	$ 256,327		$ 264,363	$ 8,037	$ 3,990,141	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 260,653	$ 27,481	$ 27,481	$	10	$ 155,739	71
72	Current Year Purchases	117,556	5,554	11,108	5,554	10	11,108	72
73	Fully Depreciated Assets	615,770					615,770	73
74	Home office allocation		61,114	61,114				74
75	TOTALS	$ 993,978	$ 94,149	$ 99,703	$ 5,554		$ 782,617	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	2000 FORD ELDORADO	1999	$ 42,261	$ 5,283	$ 5,283	$	8	$ 34,337	76
77										77
78										78
79										79
80	TOTALS			$ 42,261	$ 5,283	$ 5,283	$		$ 34,337	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,486,814	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 355,758	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 369,349	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,591	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,807,095	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation Home Office				8,680			5
6								6
7	TOTAL				$ 8,680 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 27,524 Description: Nursing - $20,513.80, Admin - $5,604.07, Dietary - $946.07, Home Office - $460
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	n/a		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	3,479	$ 181,579	$	3,479	$ 181,579	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		365	19,048		365	19,048	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		5,258	274,490		5,258	274,490	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				515,013		515,013	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	9,102	$ 475,117	$ 515,013	9,102	$ 990,130	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Provena McAuley Manor **#** 0042879 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,947,364	$	1
2	Cash-Patient Deposits	102,762		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	8,022,174		3
4	Supply Inventory (priced at)	562,029		4
5	Short-Term Investments			5
6	Prepaid Insurance	53,455		6
7	Other Prepaid Expenses	234,588		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 19,922,372	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,323,187		12
13	Land	6,872,845		13
14	Buildings, at Historical Cost	79,429,531		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	15,136,519		16
17	Accumulated Depreciation (book methods)	(44,514,067)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	133,848		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 65,381,863	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 85,304,235	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,028,501	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,196,854		28
29	Short-Term Notes Payable	35,066		29
30	Accrued Salaries Payable	2,281,363		30
31	Accrued Taxes Payable (excluding real estate taxes)	52,968		31
32	Accrued Real Estate Taxes(Sch.IX-B)	222,071		32
33	Accrued Interest Payable	26,274		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	542,408		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,385,505	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,329,784		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	219,687		42
	Other Long-Term Liabilities(specify):			
43	Conditional Asset Retirement	616,044		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,165,515	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,551,020	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 74,753,215	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 85,304,235	$	48

***(See instructions.)**

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 72,625,309	1	
2	Restatements (describe):		2	
3	**FAS47 Change in accounting principal**	(271,871)	3	
4	**Adj. To Reconcile Consolidated Equity and Consolidated**	2,044,526	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 74,397,964	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	325,604	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock	(40,261)	9	
10	Stock Options Exercised		10	
11	Contributions and Grants	240,328	11	
12	Expenditures for Specific Purposes	(170,420)	12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 355,251	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 74,753,215	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,602,358	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,602,358	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,508,420	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,508,420	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	12,452	13
14	Non-Patient Meals	13,679	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	99,024	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	47,931	20
21	Other Medical Services		21
22	Laundry	16,252	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 189,338	23
	D. Non-Operating Revenue		
24	Contributions	55,518	24
25	Interest and Other Investment Income***	3,694	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 59,212	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	145,284	28
28a	Misc. Income	73,598	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 218,882	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,578,210	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	942,779	31
32	Health Care	2,838,455	32
33	General Administration	1,608,348	33
	B. Capital Expense		
34	Ownership	300,248	34
	C. Ancillary Expense		
35	Special Cost Centers	515,013	35
36	Provider Participation Fee	47,763	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,252,606	40
41	**Income before Income Taxes (line 30 minus line 40)****	325,604	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 325,604	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,088	$ 75,809	$ 36.31	1
2	Assistant Director of Nursing	2,000	2,080	64,620	31.07	2
3	Registered Nurses	14,844	15,561	419,239	26.94	3
4	Licensed Practical Nurses	9,529	10,011	231,115	23.09	4
5	CNAs & Orderlies	55,512	60,634	775,936	12.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,561	2,826	22,526	7.97	8
9	Activity Director	1,959	2,039	31,049	15.23	9
10	Activity Assistants	5,207	5,465	35,326	6.46	10
11	Social Service Workers	2,012	2,080	32,911	15.82	11
12	Dietician	2,040	2,096	28,749	13.72	12
13	Food Service Supervisor	2,013	2,203	22,821	10.36	13
14	Head Cook	5,654	6,338	49,907	7.87	14
15	Cook Helpers/Assistants	11,794	12,486	79,655	6.38	15
16	Dishwashers					16
17	Maintenance Workers	4,709	5,034	75,778	15.05	17
18	Housekeepers	12,799	14,055	132,546	9.43	18
19	Laundry	2,181	2,340	22,929	9.80	19
20	Administrator	1,808	2,080	78,544	37.76	20
21	Assistant Administrator	1,008	1,120	28,209	25.19	21
22	Other Administrative	5,494	5,801	115,124	19.85	22
23	Office Manager					23
24	Clerical	6,224	6,803	87,085	12.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Pastoral Care	2,000	2,080	34,442	16.56	33
34	TOTAL (lines 1 - 33)	153,308	165,220	$ 2,444,320 *	$ 14.79	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	136	$ 7,091	1,3	35
36	Medical Director	$1000/mth	12,000	9,3	36
37	Medical Records Consultant	32	1,852	10,3	37
38	Nurse Consultant	16	1,280	10,3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	1,761	11,3	44
45	Social Service Consultant	11	221	12,3	45
46	Other(specify)				46
47	Podriatrist	43	6,429	9,3	47
48					48
49	TOTAL (lines 35 - 48)	261	$ 30,634		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5,724	$ 265,092	10,3	50
51	Licensed Practical Nurses	3,215	134,501	10,3	51
52	Certified Nurse Assistants/Aides	596	12,662	10,3	52
53	TOTAL (lines 50 - 52)	9,535	$ 412,255		53

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Julie Hughes	Administrator	0	$ 78,544
Administrative Staff	Asst Administrator	0	28,209
Administrative Staff	Human Resource	0	25,065
Administrative Staff	Admissions	0	81,088
Administrative Staff	Receptionist	0	45,901
Administrative Staff	Dir of Volunteer	0	5,969
Administrative Staff	Bookkeeper	0	44,186
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 308,962

B. Administrative - Other

Description	Amount
Corporate Service Fee	$ 94,800
Corporate IS Fee	66,000
Mgmt Fee	283,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 444,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Expense	Various	$ 10,323
Shredding	Various	2,183
Survey & Analytical Tools	Various	4,588
Collection Fee	Various	227
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 17,321

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,400
Unemployment Compensation Insurance	22,628
FICA Taxes	168,573
Employee Health Insurance	160,328
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	10,903
Pension	82,759
Employee Recognition	1,091
Executive Benefits	4,450
Employment Screenings	14,520
Home Office Allocation	86,435
TOTAL (agree to Schedule V, line 22, col.8)	$ 590,087

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 61)	
Employee Recruitment	3,912
Dues & Subscriptions	8,090
Advertising & Public Relations	24,991
Home Office Allocation	5,171
Less: Public Relations Expense	( )
Non-allowable advertising	(21,386)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,778

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,638
Seminar Expense	
Home Office Allocation	3,236
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,874

**See instructions.

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **Provena McAuley Manor** **#** **0042879** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **4222 - Life Service Network**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **87**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,823** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **47,763**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **13,679**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not issued yet**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.